Exhibit 15

248.298.3999
248.298.5999
907 S. Main Street, Royal Oak, MI 48067

CLEAR IMAGING

JUNE 9TH, 2010

PATIENT NAME: Redacted
DATE OF BIRTH:
FILE: 0243
REF. PHYSICIAN: KATZ, DAVID
DOS: 06/09/10

22-B133-845

MRI CERVICAL SPINE WITHOUT CONTRAST

CLINICAL HISTORY: Cervical spine pain, left arm pain, right wrist pain. Bilateral shoulder pain.

TECHNIQUE: Multiplanar images of the cervical spine were obtained without the administration of intravenous contrast.

FINDINGS:

Disc bulges are seen at the C4-5 and C5-6 levels impinging upon the thecal sac.

The C2-3, C3-4, C6-7 and C7-T1 levels appear unremarkable.

Cervical lordotic curvature is straightened probably due to musculoligamentous spasm/strain.

All the vertebrae in view show normal heights, alignment and marrow signals.

Atlantodental interval preserved. Odontoid process and atlantoaxial joint appear normal. No spinal stenosis.

Paravertebral soft tissues: Normal.

Visualized portion of the brain stem, cervical spinal cord, and upper thoracic spine appear normal.

IMPRESSION:

1. Disc bulges at the C4-5 and C5-C6 levels impinging on the thecal sac.
2. Cervical lordotic curvature is straightened probably due to musculoligamentous spasm/strain.
3. No spinal canal stenosis.
4. No vertebral fractures

Chintan Desai, MD
Diplomate, American Board of Radiology

phone 248.298.3999
fax 248.298.5999

907 S. Main Street, Royal Oak, MI 48067

CLEAR IMAGING

JUNE 9TH, 2010

PATIENT NAME: Redacted
DATE OF BIRTH:
FILE: 0243
REF. PHYSICIAN: KATZ, DAVID
DOS: 06/09/10

MRI THORACIC SPINE WITHOUT CONTRAST

CLINICAL HISTORY: Mid back pain.

TECHNIQUE: Multiplanar images of the thoracic spine were obtained without the administration of intravenous contrast.

FINDINGS:

Thoracic kyphosis is preserved.

Vertebral height, contour and marrow signals are maintained.

Disc bulges impinging upon the thecal sac at T4-5, T9-10 and T10-11 levels noted.

No evidence of spinal canal stenosis noted.

Thoracic cord is normal in bulk and signal intensity.

Prevertebral and paravertebral soft tissues are unremarkable.

IMPRESSION:

1. Disc bulges impinging upon the thecal sac at T4-5, T9-10 and T10-11 levels.
2. No vertebral fractures
3. No spinal stenosis.

Chintan Desai, MD
Diplomate, American Board of Radiology

Phone 248.298.3999
Fax 248.298.5999

907 S. Main Street, Royal Oak, MI 48067

CLEAR IMAGING

JUNE 9TH, 2010

PATIENT NAME: Redacted
DATE OF BIRTH:
FILE: 0243
REF. PHYSICIAN: KATZ, DAVID
DOS: 06/09/10

MRI LUMBAR SPINE WITHOUT CONTRAST

CLINICAL HISTORY: Lower back pain.

TECHNIQUE: Multiplanar images of the lumbar spine were obtained without the administration of intravenous contrast.

FINDINGS:
L1-L2, L2-3: Vertebral heights and marrow signal are preserved. No significant spinal canal stenosis.

L3-4: Vertebral heights and marrow signals are preserved. Disc bulge causing mild bilateral neuroforaminal narrowing. No significant spinal canal stenosis.

L4-5: Vertebral heights and marrow signals are preserved. Broad based herniation causing moderate bilateral neuroforaminal compromise. No significant spinal canal stenosis.

L5-S1. Vertebral heights and marrow signal are preserved. Disc bulge causing mild bilateral neuroforaminal compromise. No spinal stenosis.

Lumbar lordosis is preserved.

Conus and descending nerve roots appear normal in signal intensity.

Pre/paravertebral soft tissues: Unremarkable.

IMPRESSIONS:

1. Broad based herniation at L4-5 level causing moderate bilateral neuroforaminal compromise.
2. Disc bulges at L3-4 and L5-S1 levels impinging upon the thecal sac and causing mild bilateral neuroforaminal narrowing.
3. No spinal canal stenosis.
4. No vertebral fractures

Chintan Desai, MD
Diplomate, American Board of Radiology

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
FAX 888-845-8680 SEPERATELY
PO BOX 2361
BLOOMINGTON IL 61702

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)	22B133845
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX
Redacted	Redacted M X F
5.	6. PATIENT RELATIONSHIP TO INSURED
CI	Self X Spouse Child Other
ZIP	8. PATIENT STATUS
	Single Married Other X
	Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State) MI
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Redacted	
7.	
CI	
ZIP	
11.	
a. INSURED'S DATE OF BIRTH SEX	
Redacted M X F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
STATE FARM INSURANCE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.	

PATIENT AND INSURED INFORMATION

SECOND FOLD

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06 09 10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 04 07 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DAVID KATZ DC

17a.

17b. NPI 1104973007

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. L722.0
2. L728.85
3. L722.11
4. L722.10

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 09 10	06 09 10	11		72141		12	5300 00	1		NPI	1194819441
2 06 09 10	06 09 10	11		72146		3	5300 00	1		NPI	1194819441
3 06 09 10	06 09 10	11		72148		4	5300 00	1		NPI	1194819441
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

FIRST FOLD WMCF-10-ENV / WMCF-10-ENV-SS

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
270868627 X	590C344	X YES NO	$ 15900 00	$ 0 00	$ 15900 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (248)8894580
CHINTAN DESAI MD	CLEAR IMAGING LLC 907 SOUTH MAIN STREET ROYAL OAK MI 48067	CLEAR IMAGING LLC 15914 COLLECTIONS CENTER DR CHICAGO IL 60693-0159
SIGNED 06 11 10 DATE	a. 1457685257 b.	a. 1457685257 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Phone: 248.298.8999
Fax: 248.298.1999

1695 W. 12 Mile Rd. STE 240. Berkley, MI. 48072

Horizon Imaging

NAME: Redacted

REF. PHYSICIAN: GUTIERREZ, FRANK
DATE OF BIRTH: 07/26/1966
EXAM: MRI OF CERVICAL SPINE

PATIENT NUMBER: 1429-101203
STUDY DATE: 12/3/2010

HISTORY: Neck pain after motor vehicle accident.

PROCEDURE: MR imaging through the cervical spine was performed in the sagittal and axial planes utilizing T1 and T2 spin echo and gradient echo pulse sequences.

FINDINGS: The cervical vertebra are normal in signal and height. There is no fracture or bony destructive lesion. No pathologic marrow signal.

The cervical spinal cord is normal in signal and configuration. There is no cord tumor, signal abnormality, syrinx or other cord abnormality.

There is reversal of the cervical lordotic curve consistent with cervical muscular spasm.

At C2-3 and C3-4 the disks are normal. The canal and foramina are patent.

At C4-5 there is a 2 mm central disk herniation. The canal diameter is adequate. The foramina are patent.

At C5-6 there is a 2-mm somewhat broad-based herniation. The canal diameter is adequate. The foramina are patent.

At C6-7 there is a 2-mm broad-based herniation. The canal diameter is adequate. The foramina are patent.

At C7-T1 through T3-4 the disks are normal. The canal and foramina are patent.

IMPRESSION: Cervical muscular spasm.

Herniated disks at C4-5, C5-6 and C6-7.

Phone: 248.298.8999
Fax: 248.298.1999

1695 W. 12 Mile Rd. STE 240. Berkley, MI. 48072

Horizon Imaging

Michael J. Paley, MD
mjp
Electronic Signature:
Dictated on: 12/6/2010 10:18:21 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
FAX 888-845-8680 SEPERATELY
PO BOX 2361
BLOOMINGTON IL 61702

PICA ☐☐☐ — CARRIER — PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415056

2. Redacted

3. Redacted — SEX M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse ☐ Child ☐ Other ☐

7. Redacted

8. PATIENT STATUS: Single ☐ Married ☐ Other [X]; Employed ☐ Full-Time Student ☐ Part-Time Student ☐

9. Redacted

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

9b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

9c. EMPLOYER'S NAME OR SCHOOL NAME

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) ☐ YES [X] NO
b. AUTO ACCIDENT? [X] YES ☐ NO — PLACE (State) MI
c. OTHER ACCIDENT? ☐ YES [X] NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

11a. INSURED'S DATE OF BIRTH / SEX

11b. EMPLOYER'S NAME OR SCHOOL NAME

11c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES [X] NO — *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 12 03 10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

— PATIENT AND INSURED INFORMATION —

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) — 10 16 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: FRANCISC ANTONIO GUIERREZ

17a.

17b. NPI 1700041365

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES [X] NO — $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 728 85
2. 722 0
3. 722 10
4. 724 1

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 03 10	12 03 10	11		72141		12	5300 00	1		NPI	1194819441
2	12 03 10	12 03 10	11		72148		3	5300 00	1		NPI	1194819441
3	12 03 10	12 03 10	11		72146		4	5300 00	1		NPI	1194819441
4											NPI	
5											NPI	
6											NPI	

— PHYSICIAN OR SUPPLIER INFORMATION —

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN [X]: 270514243

26. PATIENT'S ACCOUNT NO.: 12500C228

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES ☐ NO

28. TOTAL CHARGE $ 15900 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 15900 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
HORIZON IMAGING LLC
SIGNED — DATE 12 06 10

32. SERVICE FACILITY LOCATION INFORMATION
HORIZON IMAGING LLC
1695 W 12 MILE RD STE 240
BERKLEY MI 48072
a. 1760701387 b.

33. BILLING PROVIDER INFO & PH. # (248)8894580
HORIZON IMAGING LLC
62048 COLLECTIONS CENTER DR
CHICAGO IL 60693
a. 1760701387 b.

SECOND FOLD — FIRST FOLD — WHCF-10-EMY / WHCF-10-EMY-SS